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GOLDEN LIVINGCENTER - EDWARDSVILLE	751 BLAKE ST. EDWARDSVILLE, KS 66111

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS60924 and #KS601467.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 92 residents divided on four separate nursing units. Based on observation, and interview the facility failed to provide services necessary to maintain a sanitary and comfortable interior of the facility for 2 of 4 resident living areas for 2 of 4 days on site of the survey. Findings included: - On 11/26/12 at 2:14 P.M. observation revealed a room on the A-hall unit with chipped ceiling finish, in the bathroom, screws sticking out from the ceiling and a peeling surface at the base of the over the sink mirror. On 11/26/12 at 11:00 A.M. observation revealed a room on the A-hall unit with missing floor tile under the resident's bed and a peeling surface at the base of the over sink mirror. On 11/26/12 at 3:44 P.M. observation revealed a room on the A hall unit with a corroded faucet in the bathroom sink and the sink was chipped and	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 with rust stains. On 11/26/12 at 12:32 P.M. observation revealed a sink in a residents room on the A-hall unit where the water would not turn off and there was no hot water in the bathroom. On 11/26/12 at 3:20 P.M. observation revealed a room on the D hall unit with water dripping under the sink. The facility policies regarding Maintenance/Housekeeping directed housekeeping and all staff to report any needed maintenance repairs to their supervisor. On 11/29/12 at 1:20 P.M. maintenance staff Z acknowledged the facility sinks and mirrors where in disrepair and said they were in the process of replacing all the sinks, mirrors and fixturing throughout the building and this was about 65 percent completed. The facility failed to maintain a clean, comfortable and homelike environment for the residents. in these areas.	F 253		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		

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F 272	Continued From page 2 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 92 residents and the sample was 21. Based on observation, record review, and staff interview the facility failed to thoroughly complete care area assessments for psychotropic medications for 2 of 10 reviewed (#64, #40).	F 272		

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F 272	Continued From page 3 Findings include: - Resident #64's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-19-12 documented the resident with a Brief Interview for Mental Status score of 15, which indicated the resident was alert and oriented. The 2-11-12 Psychoactive Medication Care Area Assessment (CAA) summary documented the resident received a regular diet, used a plate guard, covered cups, and curved utensils at meal times to maintain his/her level of feeding skills. The CAA documented the resident was able to feed his/herself, required limited to extensive assistance with all activities of daily living (ADLs), was frequently incontinent of urine and use of psychotropic medications would put the resident at risk for falls, physical decline, appetite changes, and injury. The CAA failed to address the resident's symptoms and behaviors related to the resident's use of psychotropic medications. The 8-3-12 care plan documented the resident with a potential for psychotic symptoms (paranoia, delusions, and hallucinations) related to the diagnosis of schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems) and laid on the floor, climbed on furniture, and crawled on the floor when he/she was psychotic. Interventions directed staff to refer the resident to the Behavior Management Committee, redirect the resident when delusional, encourage the resident to express his/her concerns, and remove the resident from a trigger situation.	F 272		

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The 8-3-12 care plan documented the resident with a potential for alteration in his/her mood and behavior at times related to his/her diagnosis of schizoaffective disorder as evidenced by rapid, pressured, and/or rambling speech, negative statements, repetitive fears/thinking something terrible was going to happen, restlessness, distractibility, irritability, repetitive health concerns, anxiousness, changes in sleep patters, sad/pained/worried facial expressions, withdrawal from activities and social interactions.

Observation on 11-28-12 at approximately 2:00 P.M. revealed the resident sat in a chair in the living area.

On 11-29-12 at 9:29 A.M. during staff interview, administrative staff D acknowledged the CAA lacked a comprehensive assessment of the residents psychotropic medications and stated the Mental Health Director wrote the CAAs for psychotropic medications.

On 11-29-12 at 11:15 A.M. Mental Health staff O stated he/she did not develop the CAA, but completed the mood and behavior portion of the MDS.

The facility did not provide a policy regarding Care Area Assessments.

The facility failed to identify the symptoms/behaviors for use of the psychotropic medications and failed to complete a thorough comprehensive Care Area Assessment for this resident who received psychotropic medications - Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 9/7/12 documented the resident

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F 272	Continued From page 5 with a Brief Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days of 7 days prior to the assessment. The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medication side effects that could lead to a decline in physical functioning, cardiovascular complications and behaviors. The CAA failed to address the resident's symptoms and behaviors related to the resident's use of psychotropic medications. The care plan for potential drug related complications associated with use of psychotropic medications related to anti-anxiety medication, anti-psychotic medication, mood stabilizer medications (Zyprexa, Lithium carbonate, Klonopin) dated 4/12/12 and revised 9/27/12 directed staff to monitor for side effects and report to physician and listed the side effects for the anti-anxiety/hypnotic medications. Staff should monitor for side effects of the antipsychotic medications and mood stabilizer medications and listed those possible side effects. The pharmacy was to do a monthly medication regimen reviews. Staff were directed to complete an Abnormal Involuntary Movement Scale (AIMS) quarterly and as needed. Staff should invite the resident to activities and provide 1:1 conversation to decrease target behaviors.	F 272		

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F 272	Continued From page 6 Observation on 11/27/12 at 10:23 A.M. revealed the resident walked down the hall from his/her room to the dining room and sat down at a table. During interview on 11/29/12 at 9:36 A.M. administrative staff D reported the Mental Health Director completed the Care Area Assessments for residents with behaviors. During interview on 11/29/12 at 11:15 A.M. consultant staff O reported he/she did not complete the Care Area Assessments, but did fill out the mood and behavior portion of the MDS. The facility did not provide a policy regarding Care Area Assessments. The facility failed to identify the symptoms/behaviors for use of the psychotropic medications and failed to complete a thorough comprehensive Care Area Assessment for this resident who received psychotropic medications. .	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		

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F 279	Continued From page 7 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 21 residents. Based on observation, interview and record review the facility failed to complete a comprehensive care plan for 3 of 21 residents sampled, (#74, #79, #99) for activities of daily living. Findings included: - Resident #74's quarterly Minimum Data Set (MDS) 3.0 dated 11/2/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15, which indicated intact cognition. The resident required supervision with hygiene and he/she was independent with bed mobility, transfers, ambulation, dressing and bathing with no set up or physical help from staff. The Care Area Assessment (CAA) for activities of daily living (ADL) did not trigger and was not completed. The comprehensive care plan last reviewed 11/13/12 failed to address if the resident preferred a shower or a bath. There was no	F 279		

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activity of daily living care plan to address the resident was independent with ADL's or that he/she always preferred a shower, how often he/she showered or how much assistance he/she needed with showers. The care plan did not address shaving.

Review of the resident's bath sheets revealed staff documented on 11/27/12 the resident had a bath and lotion was applied, nails cleaned and hair washed. Staff documented the resident was not shaved. On 11/26/12 the resident refused a bath and staff did not document if they offered to shave the resident.

Observation on 11/27/12 at 2:25 P.M. revealed the resident stood at the nurse's station dressed appropriately and unshaven

Observation on 11/28/12 at 2:24 P.M. revealed the resident in the hall dressed and unshaven.

During interview on 11/28/12 at 1:04 P.M. direct care staff J reported this resident preferred a shower rather than a tub bath and liked to shower more often than the regular 2 baths a week that were scheduled. Staff let him/her into the shower and he/she showered independently and then staff checked to see if he/she needs anything throughout the shower.

During interview on 11/29/12 at 9:36 A.M. administrative staff D reported if a CAA triggered then staff should care plan it.

During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident had an electric razor in the nurse's cart which he/she used to

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shave when he/she wanted. If the resident had whiskers then staff should ask his/her if he/she wanted to shave. Staff did not approach the resident very often because he/she would ask staff if he/she needed anything.

The facility failed to complete a comprehensive care plan for ADL's for this resident.

- Resident #79's quarterly Minimum Data Set (MDS) 3.0 dated 11/2/12 documented the resident required supervision with hygiene, eating and dressing and was independent with toileting, bathing, transfers, bed mobility and walking.

The Care Area Assessment (CAA) dated 2/10/12 documented the resident with depressive psychosis, psychotic condition, mood disorder and listed his/her medications. The resident was independent with activities of daily living.

The care plan for activities of daily living (ADL) dated 2/18/12 with most recent revision dated 11/16/12 documented the resident was at risk for decline in ADL self performance related to psychosis and mood disorder and an abnormal gait. Staff should monitor for increased gait problems, provide roller walker for ambulation, provide washcloths and towels for independent grooming, monitor for assistance needed to complete ADL's and encourage independent ADL's, bathing and provide assistance as needed. The resident did his/her own oral care. The care plan failed to address the resident's shaving preference.

Observation on 11/26/12 at 10:42 A.M. revealed

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the resident sat on his/her bed unshaven. Staff entered the resident's room and told him/her they would shave him/her on that day. The resident agreed with the staff.

Observation on 11/28/12 at 4:44 P.M. the resident sat in the dining room and was unshaven.

Observation on 11/29/12 at 7:40 A.M. the resident sat in the dining room eating. He/She was unshaven and his/her hair looked greasy.

During interview on 11/28/12 at 4:16 P.M. licensed nursing staff G reported staff should assist the resident with showers and shaving and document when the resident shaved on the shower sheets.

During interview on 11/29/12 at 9:36 A.M. administrative staff D reported if a CAA triggered then it should be care planned. If there was something specific for a resident then staff should care plan for that issue. Shaving and bathing were not care planned.

During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident required limited assistance with showers and help with dressing and undressing. The resident had an electric razor in his/her locked drawer in his/her room, but liked the regular shavers which nursing had. Staff shaved the resident with the regular disposable razors daily. The resident usually accepted two showers a week, but did refuse at times.

The facility failed to develop an individualized comprehensive care plan for ADL for this

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F 279	Continued From page 11 resident. - Resident #99's admission Minimum Data Set 3.0 Assessment (MDS) dated 9-26-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 15 which indicated the resident was alert and oriented. The resident required supervision with activities of daily living (ADLs) for dressing, eating, personal hygiene, and was independent with bed mobility, transfers, ambulation, toilet use, and bathing. The ADL Care Area Assessment (CAA) dated 10-10-12 documented the resident's memory was intact and his/her decision making cognitive skills were reasonable. The CAA documented per the nursing progress notes, the resident was independent with performing ADLs, and a decline in ADLs would result in a decreased self esteem and satisfaction, and place the resident at risk for skin breakdown and infection. Nursing would monitor and the resident's attending physician and psychiatrist would review as indicated. The record lacked evidence staff developed an	F 279		

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F 279	Continued From page 12 ADL care plan for this resident. Observation on 11-26-2012 at 11:18 A.M. revealed the resident laid in bed and his/her hair appeared greasy, and the resident had dirty, untrimmed nails. During staff interview on 11-29-12 at 8:29 A.M. direct care staff U stated if a resident was independent with bathing, staff checked the resident to make sure they were clean and if their fingernails needed cleaned or trimmed, encourage the resident to let staff clean the nails. On 11-29-12 at 9:29 A.M. administrative staff D acknowledged the record lacked a care plan for the resident's ADL needs and stated if it triggered on the CAA then staff should have developed a care plan for the resident. The facility failed to develop a comprehensive ADL care plan for this resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	Continued From page 13 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 21 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan to address the resident's individual preferences for bathing for 1 of 4 residents reviewed for activities of daily living (ADLs). (#29) Findings included: - Resident #29's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-5-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 11, which indicated the resident had moderately impaired decision making skills, required extensive assistance of staff with bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and personal hygiene, and required total assistance of staff with bathing. The ADL Care Area Assessment (CAA) summary documented the resident used a wheelchair for locomotion and required extensive assistance of staff with bed mobility, transfers, toileting, personal hygiene and bathing. The resident had an order for active assistance for range of motion (ROM) on his/her upper and lower extremities.	F 280		

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Because of the resident's ADL decline, he/she was at risk for skin integrity issues, further decline in physical function, depression, pain and injury.

The 10-25-12 Care Plan identified the resident with a deficit in physical function related to his/her mobility impairment and decreased ROM. Interventions directed staff to encourage the resident to make choices with care as appropriate and assist the resident with locomotion if he/she was tired. The care plan documented the resident required extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and bathing. The care plan lacked individualized interventions related to the resident's bathing preferences.

Record review of the 11-28-12 Care Sheets direct care staff referenced for residents care. The Care Sheet lacked documentation regarding the resident's preferences for bathing.

Observation on 11-26-12 at 1:05 P.M. revealed the resident in his/her room and his/her hair was uncombed and looked greasy.

On 11-26-12 at 12:49 P.M. the resident stated he/she received his/her shower in the middle of the afternoon and preferred to shower early in the morning.

On 11-28-12 at 1:05 P.M. direct care staff J stated staff gave residents a choice of when they wanted their showers or baths.

On 11-28-12 at 3:44 P.M. licensed nurse I stated the aides had sheets that documented what they needed to do for each resident, and offered

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F 280	Continued From page 15 choices of times for residents taking showers/baths. On 11-29-12 at 9:29 A.M. administrative staff D stated he/she typically did not put residents preferences on the care plan regarding bathing, shaving, and nail care. The 2006 facility provided Bath, Shower Policy and Procedure documented the Care Plan Documentation Guidelines included the amount of assistance the resident needed with bathing and any resident preferences. The facility failed to review and revise the care plan to include the resident's preferences with bathing.	F 280		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 21 residents. Based on observation, interview and record review the facility failed to provide activities of daily living (ADL) for 2 of 5 residents #74 and #79 sampled	F 310		

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for ADL's.

Findings included:

- Resident #74' quarterly Minimum Data Set (MDS) 3.0 dated 11/2/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15, which indicated intact cognition. The resident required supervision with hygiene and he/she was independent with bed mobility, transfers, ambulation, dressing and bathing with no set up or physical help from staff.

The comprehensive care plan last reviewed 11/13/12 did not address if the resident preferred a shower or a bath. There was no activity of daily living (ADL) care plan to address the resident was independent with ADL's or that he/she always preferred a shower, how often he/she showered or how much assistance he/she needed with showers. The care plan did not address shaving.

Review of the resident's bath sheets revealed staff documented on 11/27/12 the resident had a bath and lotion was applied, nails cleaned and hair washed. Staff documented the resident was not shaved. On 11/26/12 the resident refused a bath and staff did not document if he/she was offered to shave.

Review of the resident's bath sheets revealed staff documented on 11/27/12 the resident had a bath and the resident was not offered a shave. On 11/26/12 the resident refused a bath and no documentation if staff offered shaving.

Observation on 11/27/12 at 2:25 P.M. revealed the resident stood at the nurse's station dressed

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appropriately and unshaven.

Observation on 11/28/12 at 2:24 P.M. revealed the resident in the hall dressed and unshaven.

During interview on 11/28/12 at 1:04 P.M. direct care staff J reported this resident preferred a shower rather than a tub bath and liked to shower more often than the regular 2 baths a week which were scheduled. Staff let him/her into the shower and he/she showered independently and then staff checked to see if he/she needed anything throughout the shower.

During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident had an electric razor in the nurse's cart which he/she used to shave when he/she wanted. If the resident had whiskers then staff should ask his/her if he/she wanted to shave. Staff did not approach the resident very often because he/she asked staff if he/she needed anything.

The facility failed to provide assistance with shaving for this resident.

- Resident #79's quarterly Minimum Data Set (MDS) 3.0 dated 11/2/12 documented the resident required supervision with hygiene, eating, dressing and was independent with toileting, bathing, transfers, bed mobility and walking.

The Care Area Assessment (CAA) dated 2/10/12 documented the resident with depressive psychosis, psychotic condition, mood disorder and listed his/her medications. The resident was

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F 310	Continued From page 18 independent with activities of daily living. The care plan for activities of daily living (ADL) dated 2/18/12 with most recent revision dated 11/16/12 documented the resident was at risk for decline in ADL self performance related to psychosis and mood disorder and an abnormal gait. Staff should monitor for increased gait problems, provide roller walker for ambulation, provide washcloths and towels for independent grooming, monitor for assistance needed to complete ADL's and encourage independent ADL's, bathing and provide assistance as needed. The resident did his/her own oral care. The care plan failed to address the resident's shaving preference. Review of the resident's bath sheets revealed on 11/26/12 the resident refused a bath, but failed to document if staff offered shaving. On 10/29/12 the resident showered independently. On 11/2/12 the resident bathed, hair washed, but he/she was not shaved. The record lacked documentation of resident refusals to shave. Observation on 11/26/12 at 10:42 A.M. revealed the resident sat on his/her bed unshaven. Staff entered the resident's room and told him/her they would shave him/her on that day. The resident agreed with the staff. Observation on 11/28/12 at 4:44 P.M. the resident sat in the dining room and was unshaven. Observation on 11/29/12 at 7:40 A.M. the resident sat in the dining room eating. He/She was unshaven and his/her hair looked greasy.	F 310		

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F 310	Continued From page 19 During interview on 11/28/12 at 4:16 P.M. licensed nursing staff G reported staff should assist the resident with showers and shaving and document when the resident shaved on the shower sheets. During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident required limited assistance with showers and help with dressing and undressing. The resident had an electric razor in his/her locked drawer in his/her room, but liked the regular shavers which nursing had. Staff shaved the resident with the regular disposable razors daily. The resident usually accepted two showers a week, but did refuse at times. The facility failed to provide assistance with shaving and cleaning this resident's hair.	F 310		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

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F 329	Continued From page 20 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 21 residents. Based on observation, interview, and record review the facility failed to document behavior monitoring for psychotropic medications for 3 of 10 residents reviewed for medications. (#64, #3, #40) Findings included: - Resident #64's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-19-12 documented the resident with a Brief Interview for Mental Status score of 15, which indicated the resident was alert and oriented. The 2-11-12 Psychoactive Medication Care Area Assessment (CAA) summary documented the resident received a regular diet, used a plate guard, covered cups, and curved utensils at meal times to maintain his/her level of feeding skills. The CAA documented the resident was able to feed his/herself, required limited to extensive assistance with all activities of daily living (ADLs), was frequently incontinent of urine and use of psychotropic medications put the resident at risk for falls, physical decline, appetite changes, and	F 329		

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injury.

The 8-3-12 care plan documented the resident with a potential for psychotic symptoms (paranoia, delusions, and hallucinations) related to the diagnosis of schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems) and laid on the floor, climbed on furniture, and crawled on the floor when he/she was psychotic. Interventions directed staff to refer the resident to the Behavior Management Committee, redirect the resident when delusional, encourage the resident to express his/her concerns, and remove the resident from a trigger situation.

The 8-3-12 care plan documented the resident with a potential for alteration in his/her mood and behavior at times related to his/her diagnosis of schizoaffective disorder as evidenced by rapid, pressured, and/or rambling speech, negative statements, repetitive fears/thinking something terrible was going to happen, restlessness, distractibility, irritability, repetitive health concerns, anxiousness, changes in sleep patterns, sad/pained/worried facial expressions, withdrawal from activities and social interactions.

Record review of the November 2012 Physician's Order Sheet (POS) documented the physician ordered staff to give the resident Lexapro (and anti-depressant medication) 20 milligrams (mg) daily beginning 10-20-12, Depakote (an anti-psychotic medication) 250 mg daily beginning 2-9-11, Zyprexa (an anti-psychotic) 10 mg daily beginning 8-22-12, Zyprexa Zydis 10 mg as needed for schizoaffective disorder beginning

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F 329	Continued From page 22 6-11-11, Clonazepam (an anti-anxiety medication) 1 mg twice daily beginning 6-19-11. The September 2012 Behavior Monthly Flow Sheet documented the resident received Lexapro and Zyprexa Zydis for Schizoaffective disorder. Staff monitored the resident for anxiety, depression, withdrawal, and false beliefs. The Flow Sheet lacked documentation the resident received Depakote or Clonazepam. The October 2012 Behavior Monthly Flow Sheet lacked medications the resident received for his/her behaviors staff monitored that included anxiety, depression, withdrawal and false beliefs. The November 2012 Behavior Monthly Flow Sheet documented the resident received Lexapro and lacked documentation the resident received Depakote, Zyprexa, and Clonazepam. The Flow sheet documented staff monitored the resident for anxiety, depression, withdrawal and false beliefs. Observation on 11-28-12 at approximately 2:00 P.M. revealed the resident sat in a chair in the living area. During staff interview on 11-28-12 at 2:51 P.M. direct care staff Q stated they were made aware of each residents behaviors on the Care Sheet provided to direct care staff and reported any behaviors to the nurses. During staff interview on 11-28-12 at 4:16 P.M. licensed nurse G reported staff documented behaviors on the Behavior Monitoring Sheets in the Medication Administration Record (MAR).	F 329		

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F 329	Continued From page 23 He/she acknowledged the medications were not listed with the behavior for the Depakote or other antipsychotic medications on the sheet. The facility failed to document behavior monitoring for psychotropic medications for this resident. - Resident #3's quarterly Minimum Data Set (MDS) 3.0 dated 8/18/12 documented the resident with a Brief Interview for Mental Status Score of 14, which indicated the resident with intact cognition. The resident had hallucintations and delusions and took antipsychotic and antianxiety medications on 7 days during the 7 days prior to the assessment. The Care Area Assessment for behaviors dated 11/28/11 documented the resident refused showers but staff convinced him/her to shower and he/she required daily redirection by staff to shower. The Care Area Assessment for psychotropic medications dated 11/28/11 documented the resident with diagnoses of schizoaffective disorder, history of rash and other skin eruption, depressive disorder, history of pain, hypertension, esophageal reflux, extrapyramidal disease, abnormal movement disorder and hypothroidism. The resident was able to communicate his/her needs to staff. He/She refused to participate in	F 329		

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personal hygiene and bathing activities. He/She had episodes of refusing meals. He/She slept mostly during the day and had delusions and hallucinations and believed he/she was pregnant at times. The resident seemed to hear voices and responded to the voices. The resident's current medications consisted of Fluphenazine, Risperdal, Enalapril, Lexapro, Clonazepam, Risperdal consta and Topamaz. The resident was at risk for falls, side effects and adverse effects related to the medications.

The care plan for schizoaffective disorder and depressive disorder dated 11/28/11 last revised 8/30/12 directed staff to observe the resident's moods/behaviors and track them using the Kiosk Care Tracker.

The care plan dated 11/28/11 for antidepressant use of Lexapro, hypnotic use of Ambien and Clonazepam, Fluphenazine, Risperdal, Enalapril and Topamax directed staff to observe for the side effects of those medications and listed those side effects.

The comprehesive care plan dated 8/30/12 documented the resident with inappropriate behaviors related to schizoaffective disorder that included being argumentative, throwing things, yelling at staff, usually after hallucinations or delusional thinking. Staff were to redirect, assess and encourage the resident to express thoughts and notify the physician and psychiatrist of significant changes.

The 11/6/12 Physician Order Sheet ordered staff to give the resident Effexor XR (a medication for depression)75 milligrams (mg) every day

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begining 10/10/12, Risperdal consta 50 mg intramuscular injection every 14 days at bed time for schizophrenia (a cognitive/behavior disorder) begining 12/15/09, Clonazepam (a medication for seizures and panic disorders) 2 mg every 8 hours for schizophrenia begining 9/16/10, Depakote ER (a medication for mood disorders and siezures) 500 mg every day for depression begining 8/24/11, Fluphenazine (a medication for psychotic disorders and schizophrenia) 10 mg every 6 hours as needed for schizophrenia since 12/15/09 and Risperdal 4 mg twice daily for schizophrenia begining 2/24/10.

The Behavior Monthly Flow Sheet for 9/2012 and 10/2012 revealed staff documented the resident did not have depression, false beliefs, hallucinations and was not agitated, anxious or compulsive. Staff did not list what medications were being given for the behaviors. The November 2012 Behavior Monitoring Sheet for agitation, anxiety, compulsiveness, depression, false beliefs and hallucinations, paranoia and delusions listed Effexor as the medication being used for those target behaviors. Staff failed to list the other psychotropic medications on this sheet and failed to document behavior monitoring for the Risperdal consta, Clonazepam, Depakote, Fluphenazine and Risperdal.

Observation on 11/27/12 at 4:28 P.M. revealed the resident sat in the dining room leaning forward in the chair with his/her hands over their face.

During interview on 11/28/12 at 4:16 P.M. licensed nursing staff G reported staff document behaviors on the Behavior Monitoring sheets in

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the Medication Administration Record (MAR). He/She acknowledged the medications were not listed with the behavior for the risperdol or other antipsychotic medications on the sheet, but if the resident did not have any behaviors then the medications were effective.

During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident talked to himself/ herself and thought people were talking about him/her. The resident also yelled out.

The facility failed to document behavior monitoring for psychotropic medications for this resident.

- Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 9/7/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days for the 7 days prior to the assessment.

The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medication side effects that could lead to a decline in physical functioning, cardiovascular complications and behaviors.

The care plan for potential drug related complications associated with use of psychotropic medications related to anti-anxiety medication, anti-psychotic medication, mood stabilizer

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medications (Zyprexa, Lithium carbonate, Klonopin) dated 4/12/12 and revised 9/27/12 directed staff to monitor for side effects and report to physician and listed the side effects for the anti-anxiety/hypnotic medications. Staff should monitor for side effects of the antipsychotic medications and mood stabilizer medications and listed those possible side effects. The pharmacy was to do monthly medication regimen reviews. Staff were directed to complete an Abnormal Involuntary Movement Scale (AIMS) quarterly and as needed. Staff should invite the resident to activities and provide 1:1 conversation to decrease target behaviors.

The Physician Order Sheet dated 11/6/12 ordered staff to give the resident Zyprexa 20 milligrams (mg) at bed time for schizophrenia begining 7/15/9, lithium carbonate 300 mg at 4:00 P.M. for paranoid schizophrenia begining 5/10/12 and Klonopin 0.5 mg twice a day for schizophrenia begining 7/15/09.

The Behavior Monthly Flow Sheet for September 2012 and October 2012 revealed staff documented the resident had no anxiety, depression, false beliefs, hallucinations/paranoia/delusions or nervousness. Staff did not indicate what medications they monitored for those behaviors and medications were not listed on the behavior sheet.

Observation on 11/27/12 at 10:23 A.M. revealed the resident walked down the hall from his/her room to the dining room and sat down at a table.

During interview on 11/28/12 at 4:16 P.M.

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F 329	Continued From page 28 licensed nursing staff G reported staff document behaviors on the Behavior Monitoring sheets in the Medication Administration Record (MAR). He/She acknowledged the medications were not listed with the behavior for the resident's antipsychotic medications, but if the resident did not have any behaviors then the medications were effective. The facility failed to monitor behaviors for this resident with psychotropic medications.	F 329		
F 428 SS=D	. 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 92 residents. The sample included 21 residents. Based on observation, interview, and record review the facility failed to document behavior monitoring for psychotropic medications for 3 of 10 residents reviewed for medications. (#64, #3, #40) Findings included:	F 428		

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- Resident #64's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 10-19-12 documented the resident with a Brief Interview for Mental Status score of 15, which indicated the resident was alert and oriented.

The 2-11-12 Psychoactive Medication Care Area Assessment (CAA) summary documented the resident received a regular diet, used a plate guard, covered cups, and curved utensils at meal times to maintain his/her level of feeding skills. The CAA documented the resident was able to feed his/herself, required limited to extensive assistance with all activities of daily living (ADLs), was frequently incontinent of urine and use of psychotropic medications put the resident at risk for falls, physical decline, appetite changes, and injury.

The 8-3-12 care plan documented the resident with a potential for psychotic symptoms (paranoia, delusions, and hallucinations) related to the diagnosis of schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems) and laid on the floor, climbed on furniture, and crawled on the floor when he/she was psychotic. Interventions directed staff to refer the resident to the Behavior Management Committee, redirect the resident when delusional, encourage the resident to express his/her concerns, and remove the resident from a trigger situation.

The 8-3-12 care plan documented the resident with a potential for alteration in his/her mood and behavior at times related to his/her diagnosis of

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schizoaffective disorder as evidenced by rapid, pressured, and/or rambling speech, negative statements, repetitive fears/thinking something terrible was going to happen, restlessness, distractibility, irritability, repetitive health concerns, anxiousness, changes in sleep patterns, sad/pained/worried facial expressions, withdrawal from activities and social interactions.

Record review of the November 2012 Physician's Order Sheet (POS) documented the physician ordered staff to give the resident Lexapro (and anti-depressant medication) 20 milligrams (mg) daily beginning 10-20-12, Depakote (an anti-psychotic medication) 250 mg daily beginning 2-9-11, Zyprexa (an anti-psychotic) 10 mg daily beginning 8-22-12, Zyprexa Zydis 10 mg as needed for schizoaffective disorder beginning 6-11-11, Clonazepam (an anti-anxiety medication) 1 mg twice daily beginning 6-19-11.

The September 2012 Behavior Monthly Flow Sheet documented the resident received Lexapro and Zyprexa Zydis for Schizoaffective disorder. Staff monitored the resident for anxiety, depression, withdrawal, and false beliefs. The Flow Sheet lacked documentation the resident received Depakote or Clonazepam.

The October 2012 Behavior Monthly Flow Sheet lacked medications the resident received for his/her behaviors staff monitored that included anxiety, depression, withdrawal and false beliefs.

The November 2012 Behavior Monthly Flow Sheet documented the resident received Lexapro and lacked documentation the resident received Depakote, Zyprexa, and Clonazepam. The Flow

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sheet documented staff monitored the resident for anxiety, depression, withdrawal and false beliefs.

Observation on 11-28-12 at approximately 2:00 P.M. revealed the resident sat in a chair in the living area.

During staff interview on 11-28-12 at 2:51 P.M. direct care staff Q stated they were made aware of each residents behaviors on the Care Sheet provided to direct care staff and reported any behaviors to the nurses.

During staff interview on 11-28-12 at 4:16 P.M. licensed nurse G reported staff documented behaviors on the Behavior Monitoring Sheets in the Medication Administration Record (MAR). He/she acknowledged the medications were not listed with the behavior for the Depakote or other antipsychotic medications on the sheet.

Review of the monthly Pharmacy Regimen Reviews from January 2012 though 11-23-12 revealed no suggestions of the need to monitor behaviors related to the resident's individual psychotropic medications.

During an interview on 11-29-12 at 4:30 P.M. Consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and acknowledged the Behavior Monthly Flow Sheets lacked the medications the resident received for behaviors.

The Pharmacy Consultant failed to recognize and report to the facility the irregularity that the facility

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F 428	Continued From page 32 failed to effectively monitor the efficacy of the psychoactive medications residents received. - Resident #3's quarterly Minimum Data Set (MDS) 3.0 dated 8/18/12 documented the resident with a Brief Interview for Mental Status Score of 14, which indicated the resident with intact cognition. The resident had hallucintations and delusions and took antipsychotic and antianxiety medications on 7 days during the 7 days prior to the assessment. The Care Area Assessment for behaviors dated 11/28/11 documented the resident refused showers but staff convinced him/her to shower and he/she required daily redirection by staff to shower. The Care Area Assessment for psychotropic medications dated 11/28/11 documented the resident with diagnoses of schizoaffective disorder, history of rash and other skin eruption, depressive disorder, history of pain, hypertension, esophageal reflux, extrapyramidal disease, abnormal movement disorder and hypothroidism. The resident was able to communicate his/her needs to staff. He/She refused to participate in personal hygiene and bathing activities. He/She had episodes of refusing meals. He/She slept mostly during the day and had delusions and hallucinations and believed he/she was pregnant at times. The resident seemed to hear voices and responded to the voices. The resident's current medications consisted of Fluphenazine, Risperdal, Enalapril, Lexapro, Clonazepam,	F 428		

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Risperdal consta and Topamaz. The resident was at risk for falls, side effects and adverse effects related to the medications.

The care plan for schizoaffective disorder and depressive disorder dated 11/28/11 last revised 8/30/12 directed staff to observe the resident's mood/behavior and track them using the Kiosk Care Tracker.

The care plan dated 11/28/11 for antidepressant use of lexapro, hypnotic use of Ambien and Clonazepam, Fluphenazine, Risperdal, Enalapril and Topamax directed staff to observe for the side effects of those medications and listed those side effects.

The comprehensive care plan dated 8/30/12 documented the resident with inappropriate behaviors related to schizoaffective disorder that included being argumentative, throwing things, yelling at staff, usually after hallucinations or delusional thinking. Staff were to redirect, assess and encourage the resident to express thoughts and notify the physician and psychiatrist of significant changes.

The 11/6/12 Physician Order Sheet ordered staff to give the resident Effexor XR (a medication for depression)75 milligrams (mg) every day beginning 10/10/12, Risperdal consta 50 mg intramuscular injection every 14 days at bed time for schizophrenia (a cognitive/behavior disorder) beginning 12/15/09, Clonazepam (a medication for seizures and panic disorders) 2 mg every 8 hours for schizophrenia beginning 9/16/10, Depakote ER (a medication for mood disorders and seizures) 500 mg every day for depression

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beginning 8/24/11, Fluphenazine (a medication for psychotic disorders and schizophrenia) 10 mg every 6 hours as needed for schizophrenia12/15/09 and Risperdal 4 mg twice daily for schizophrenia beginning 2/24/10.

The Behavior Monthly Flow Sheet for 9/2012 and 10/2012 revealed staff documented the resident did not have depression, false beliefs, hallucinations and was not agitated, anxious or compulsive. Staff did not list what medications were being given for the behaviors. The November 2012 Behavior Monitoring Sheet for agitation, anxiety, compulsiveness, depression, false beliefs and hallucinations, paranoia and delusions listed Effexor as the medication being used for those target behaviors. Staff failed to list the other psychotropic medications on this sheet and failed to document behavior monitoring for the Risperdal consta, Clonazepam, Depakote, Fluphenazine and Risperdal.

Review of the monthly Pharmacy Regimen Reviews for the past year with last review on 11/23/12 revealed no suggestion of the need to monitor behaviors related to the resident's individual psychotropic medications.

Observation on 11/27/12 at 4:28 P.M. revealed the resident sat in the dining room leaning forward in the chair with his/her hands over their face.

During interview on 11/28/12 at 4:16 P.M. licensed nursing staff G reported staff document behaviors on the Behavior Monitoring sheets in the Medication Administration Record (MAR). He/She acknowledged the medications were not

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listed with the behavior for the risperdol or other antipsychotic medications on the sheet, but if the resident did not have any behaviors then the medications were effective.

During interview on 11/29/12 at 2:09 P.M. direct care staff K reported the resident talked to himself/ herself and thought people were talking about him/her. The resident also yelled out.

During interview on 11/29/12 at 3:30 P.M. consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and in a psychiatric setting there could be a lot of lee-way for behavior monitoring.

The Pharmacy Consultant P failed to recognize and report to the facility, the irregularity that the facility failed to effectively monitor the efficacy of these psychoactive medications.

- Resident #40's Quarterly Minimum Data Set (MDS) 3.0 dated 9/7/12 documented the resident with a Brief Interview for Mental Status score (BIMS) of 15 which indicated the resident with intact cognition. The resident received antipsychotic and antianxiety medications on 7 days for the 7 days prior to the assessment.

The Care Area Assessment (CAA) dated 4/13/12 for antipsychotic medications documented the resident took Zyprexa, Lithium carbonate and Klonopin. The resident was compliant with medications and cares. The resident was at risk for antipsychotic medication side effects that could lead to a decline in physical functioning,

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cardiovascular complications and behaviors.

The care plan for potential drug related complications associated with use of psychotropic medications related to antia-anxiety medication, anti-psychotic medication, mood stabilizer medications (Zyprexa, Lithium carbonate, Klonopin) dated 4/12/12 and revised 9/27/12 directed staff to monitor for side effects and report to physician and listed the side effects for the anti-anxiety/hypnotic medications. Staff should monitor for side effects of the antipsychotic medications and mood stabilizer medications and listed those possible side effects. The pharmacy was to do a monthly medication regimen reviews. Staff were directed to complete an Abnormal Involuntary Movement Scale (AIMS) quarterly and as needed. Staff should invite the resident to activities and provide 1:1 conversation to decrease target behaviors.

The Physician Order Sheet dated 11/6/12 ordered staff to give the resident Zyprexa 20 mg at bed time for schizophrenia beginning 7/15/9, lithium carbonate 300 mg at 4:00 P.M. for paranoid schizophrenia beginning 5/10/12 and Klonopin 0.5 mg twice a day for schizophrenia beginning 7/15/9.

The Behavior Monthly Flow Sheet for September 2012 and October 2012 revealed staff documented the resident had no anxiety, depression, false beliefs, hallucinations/paranoia/delusions or nervousness. Staff did not indicate what medications they monitored for those behaviors and medications were not listed on the behavior sheet.

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F 428	Continued From page 37 Review of the monthly Pharmacy Regimen Review for the past year with last review on 10/17/12 revealed no suggestion of the need for the facility to monitor behaviors related to the resident's individual psychotropic medications. Observation on 11/27/12 at 10:23 A.M. revealed the resident walked down the hall from his/her room to the dining room and sat down at a table. During interview on 11/28/12 at 4:16 P.M. licensed nursing staff G reported staff document behaviors on the Behavior Monitoring sheets in the Medication Administration Record (MAR). He/She acknowledged the medications were not listed with the behavior for the resident's antipsychotic medications, but if the resident did not have any behaviors then the medications were effective. During interview on 11/29/12 at 3:30 P.M. consultant staff P reported he/she was unsure if the facility could monitor resident behaviors specific to individual psychotropic medications and in a psychiatric setting there could be a lot of leeway for behavior monitoring. The Pharmacy Consultant P failed to recognize and report to the facility, the irregularity that the facility failed to effectively monitor the efficacy of these psychoactive medications. .	F 428		